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ABSTRACT

Path analysis was used on survey responses of 1106 persons age 50 or over. Stage one variables were recent retirement, recent widowhood or divorce, age, and sex. Stage two variables included self-rated health, functional health, health trend, and self-rated income adequacy. It was expected that these variables might directly affect morale or indirectly affect it through the stage three variables of total activity space and activity deficit. The stage three variables were also expected to have some direct effect on morale scores. Self-rated health was by far the most important predictor of morale, followed by health trend, activity space, activity deficit, and income adequacy. These five variables accounted for 29% of the variation in morale. (Author/NFD)

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PREDICTORS OF MORALE[1]

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The essence of morale is outlook on life. When we say that people have a good outlook on life we mean that when they look at the world around them, their attitude toward that world in general is a positive one. This is not the only meaning of morale, but it is the meaning most often used by social gerontologists. Gerontologists are interested in morale because it is a major element in the subjective assessment of life's quality. In assessing the adequacy of society's functioning in relation to its older members, we are interested in how various social elements combine to influence the quality of life for those people. And morale is a major characteristic of that quality.

General outlook on life has variously been referred to as morale, life satisfaction, or social adjustment. Regardless of the term used, there is a high degree of overlap in the questions used to measure subjective assessments of a person's well-being (Lohmann, 1977). Many studies have looked at simple, two-way relationships between various social factors and morale. Morale has generally been found to be unrelated to role changes such as the empty nest (Glenn, 1975) or retirement (Simpson, Back, and McKinney, 1966; Streib and Schneider, 1972; Cottrell and Atchley, 1969). Yet unsupported references in the literature about the negative impact of role change on morale continue to appear and to be accepted by reviewers.

On the other hand, poor health has been found to be strongly

related to low morale (Chatfield, 1977; Simpson, Back, and McKinney, 1966; Palmore and Luikart, 1972; Spreitzer and Snyder, 1974). Clark and Anderson (1967) found that physical dependency was a primary cause of low morale among older people. Low morale has also been linked to financial difficulties (Chatfield, 1977; Edwards and Klenimack, 1973; Spreitzer and Snyder, 1974), and to financial dependency (Clark and Anderson, 1967). Edwards and Klemmack (1973) found that life satisfaction was related to social activity level.

In a recent study, Palmore and Kivett (1977) looked at change in life satisfaction over a four-year period in relation to initial scores on self-rated health, organizational activity, hours of social activity, productive (instrumented activity) hours, sexual enjoyment, age, sex, income, education, physical functioning, number of social contacts, employment, career anchorage, having a confidant, marital status, number of moves, and intelligence. Only the first five of these were related to life satisfaction initially; therefore, the change data were examined only in relation to these five. Life satisfaction at the end of four years was most strongly related to initial level of self-rated health, followed by sexual enjoyment, and social activity hours. These three factors "explained" 28 percent of the variation in life satisfaction.

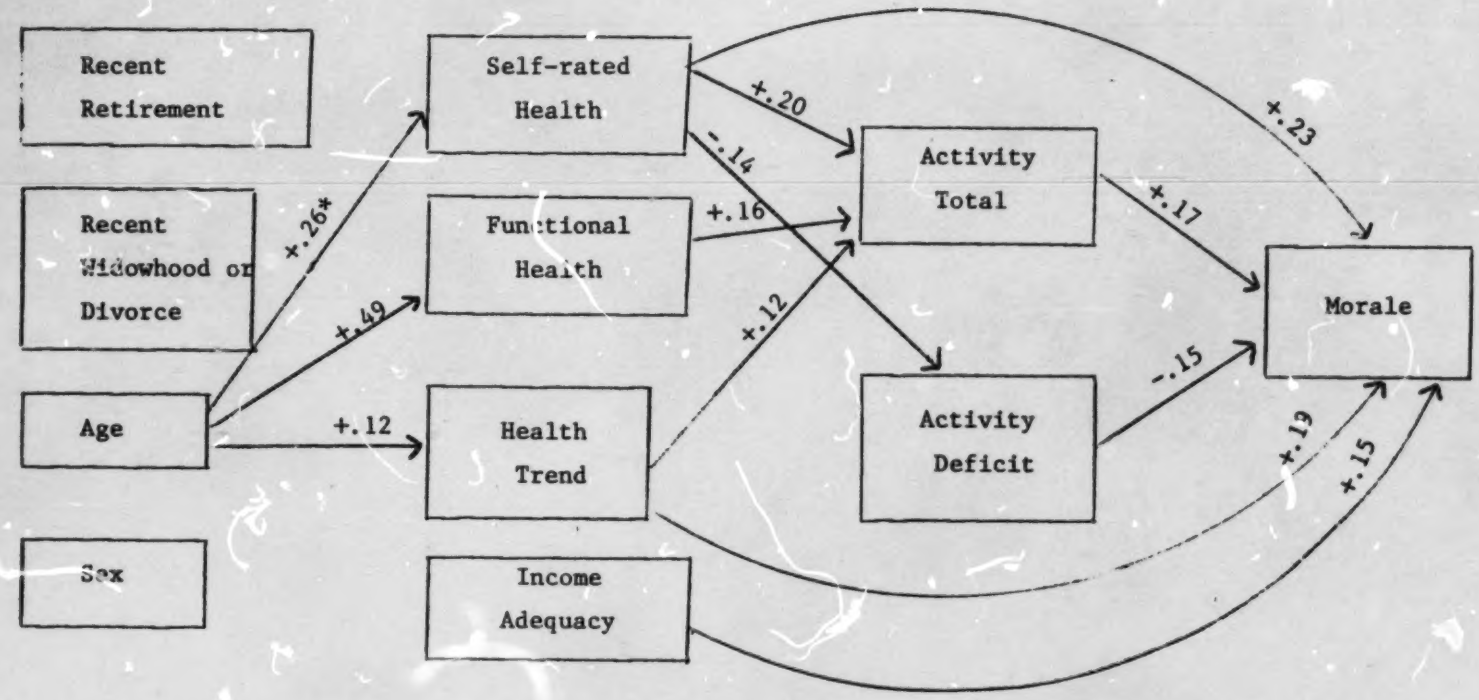
Thus, the weight of previous research leads to a conclusion that role change is not a strong correlate of morale but that

health, income adequacy, and social activity are all related to morale. However, none of the previous studies has developed or evaluated a theoretical model to explain how various factors influence morale.

This research was designed to look at a number of competing causes of low morale. There were three levels of causes that needed to be considered. On the first level were role changes: retirement and widowhood or divorce, income adequacy, and two demographic characteristics: chronological age and sex. The second level of causes were physical characteristics such as health or physical disability. The third level related to social activity.

Path analysis is primarily a theoretical framework for analyzing data from multiple regression. It allows the researcher to evaluate empirically from regression data a theoretical model of causal relations. The model to be evaluated in this research is shown in Figure 1.

The stage one variables could affect morale directly or through their affect on stage two or stage three variables. Likewise, stage two variables could directly affect morale or affect it indirectly through their impact on stage three variables. There is an assumption in the model that health variables do not influence retirement or widowhood. This assumption is supported by low correlations between health variables and retirement or widowhood. The arrows in Figure 1 indicate those relationships that were found to be significant. Others



*Standardized beta coefficients significant at the .05 level or less.

Figure 1. A Model of Causes of Morale

were omitted to avoid cluttering up the diagram. These results will be discussed more fully later in the paper.

Method

In the fall of 1975, questionnaires were mailed to 1500 people age 50 or over who were residents of a rural township located in Ohio. The township contains a small town of about 15,000 population. People were identified in two ways: Board of Elections records, which contained names, addresses, and birthdates of registered voters, and a postcard census of all mailing addresses in the township. 1106 returns were received, a response rate of 73 percent. Of those who responded, 42 percent were male and 58 percent were female. 43 percent were retired, 57 percent were not. The median age of the respondents was 63. The median years of school completed was 15.3. As an aside, even among the farm population of the township, there is a high percentage of college graduates.

The variables in the analysis reported here included age, sex, recent widowhood or divorce, recent retirement, self-reported health, functional health, health trend, total activity space, activity deficit, income adequacy, and morale. "Recent" widowhood, divorce, or retirement means that the event occurred within the past year. We experimented with various intervals up to 5 years. How "recent" is defined does not affect the results. Self-rated health was measured by an item, "How would you rate your health?", with response categories ranging from very good to

very poor. Functional health was measured by a scale of ability to perform physical tasks such as walking a mile or walking up and down stairs. Health trend was measured by a single item: "In general, would you say that your health is improving, declining, or remaining the same?" Total activity space was measured by the individual's ratings of how frequently ("never" or "very often") he or she engaged in each of 18 categories of activities such as gardening, participatory sports or games, handiwork, social activities, traveling, reading, or watching television. Activity deficit was the amount of space remaining in those activity categories that the respondents checked they would like to do more often. Income adequacy was measured by one item. "Do you consider your current family income enough to meet your living expenses?" (yes, no). Morale was measured by a scale developed by Lawton (1972).

Results

As Figure 1 shows, of the stage one variables of age, sex, retirement, and widowhood or divorce, only age produced significant results. Age has no direct effect on morale, but it has a mild indirect effect through its influence on various health measures. It is noteworthy that the "social structure" variables had little to do with morale. This presents quite a contrast to the general rhetoric but is quite consistent with previous research.

At stage two, several direct and indirect effects can be observed. Self-rated health has a very high direct effect on morale. In addition, it has sizable indirect effects on morale

through both activity variables. Functional health influences morale only indirectly through its influence on total activity space. Health trend has only a direct effect, but it is high in magnitude. Income adequacy has a direct effect and an indirect effect through total activity space. Table 1 shows the results of the regression analysis of direct effects. Self-rated health is by far the most powerful predictor of morale, followed by health trend, total activity space, activity deficit and income adequacy. Together, these five variables account for 29 percent of the variation in morale.

In most respects, this study confirms the results of previous research. Health, social activity, and income difficulties are all strongly related to morale. Retirement is unrelated to morale. This research also supports previous findings that morale is unrelated to marital status. The results do not match those of previous research with regard to the effect of socioeconomic status. Earlier studies reported a significant correlation between socio-economic status and morale (Edwards and Klemmack, 1973; Spreitzer and Snyder, 1974). In this study, morale was not significantly correlated with either income or education. This contradiction may be the result of failure to control for income adequacy. There is a moderate positive correlation between amount of income and perceived income adequacy. If previous research had controlled for income adequacy, the relationship between income and morale may have disappeared. Indeed, the most recent studies that used multi-variate data analysis, this study and that of Palmore and Kivett (1977),

Table 1. Regression Analysis of Direct Predictors of Morale

	Multiple R	Cumulative R Square	Simple R	Standardized Beta Coefficient*
Activity Deficit	.20	.04	-.20	-.15
Income Adequacy	.33	.11	+.27	+.15
Self-rated Health	.48	.23	+.41	+.23
Health Trend	.52	.27	+.28	+.19
Total Activity Space	.54	.29	+.33	+.17

*All beta coefficients reported are significant at the .05 level or less.

report no significant relationship between income and morale.

The major contribution of this study is in providing some clues as to how various factors combine to influence morale. For example, the reason why age is unrelated to morale seems to be as follows. Age is strongly related to functional health, but functional health does not directly affect morale. It affects morale only through activity (see Figure 1). Thus, the indirect effects of age on morale are tertiary indirect effects and therefore it is unsurprising that age is not highly correlated with morale. There are simply too many intervening contingencies.

Summary and Discussion

This research empirically demonstrates the centrality of health to the morale of older people. Next to the importance of health, activity and income adequacy come in a distant second (see Table 1). Poor health itself lowers a person's positive outlook on life. We all know this intuitively. On days when we feel ill, it is difficult to be cheerful, optimistic, energetic, and so on. In addition, when people feel ill, it is difficult for them to be as active as they might want to be. It is noteworthy that feeling deprived in terms of activity level is an important contributor to low morale. Also, if we assume that freedom from chronic worry is a prerequisite for a positive outlook, it is unsurprising that people who have difficulty scraping together enough money to live on tend to have a low morale.

Health, activity, and income adequacy are significantly

correlated. In the case of activity, it seems reasonable to assume that poor health and/or inadequate income depress activity level and not the other way around. However, the causal connection between poor health and inadequate income is not clear. Inadequate income definitely leads to poor nutrition, poor health care, and/or poor housing, all of which can lead to poor general health. But poor health can interfere with a person's ability to generate income. Because opportunities to manipulate income generally lessen with age, it seems reasonable to assume that inadequate income leads to poor health more often than poor health leads to inadequate income.

The theoretical model evaluated in this research fits the variation in morale reasonably well compared to how such models fare in social sciences generally. For example, the model presented here accounted for 29 percent of the variation in morale compared to 8 percent accounted for by the model used by Palmore and Kivett (1977). Our next step is to see if we can further improve the model by including effects of health, activity, and income adequacy variables on specific social psychological indicators such as anxiety which in turn may directly affect a person's general outlook.

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